MONTANA
Department of Public Health & Human Services

SCREENING FORM BREAST AND CERVICAL

MONTANA
BREAST & CERVICAL HEALTH PROGRAM

Client Name (Last, First, MI)_____Phone _____ Admin Site #_____

Social Security Number _____-_____-_____ Date of Birth____/____/____ ☐ Revised

BREAST CANCER SCREEN RESULTS

Date of Clinical Breast Exam _____/_____/_____
Month Day Year

Clinical Breast Exam (CBE) findings

- ☐ Normal exam
- ☐ Benign findings
- ☐ **Abnormal, suspicious for cancer**
- ☐ CBE not done

Date of Mammogram _____/_____/_____
Month Day Year

Mammogram type ☐ **Digital** ☐ **Conventional**

Mammography test results - *BI-RAD Categories*

- ☐ Negative: Category 1
- ☐ Benign: Category 2
- ☐ Probably benign short interval follow-up suggested: Category 3
- ☐ **Suspicious Abnormality: Category 4**
- ☐ **Highly suggestive of malignancy: Category 5**
- ☐ **Assessment Incomplete: Category 0**

Paid by the MBCHP Mammogram ☐ Yes ☐ No
CBE ☐ Yes ☐ No

Reason for Mammography test

- ☐ Routine screening
- ☐ Evaluate symptoms**,** positive CBE/previous abnormal mammogram
- ☐ Done outside the MBCHP, diagnostics only
- ☐ Not done only received CBE or diagnostics
- ☐ Cervical record only

Date referred to the MBCHP for diagnostic workup

Date referred _____/_____/_____
Month Day Year

Additional procedures

- ☐ Not planned, normal follow-up
- ☐ Planned, further diagnostic tests needed

Next breast screening or follow-up due _____/_____
Month Year

Recommendations/comments_____

_____

Print Provider's Name_____

Provider's signature_____

CERVICAL CANCER SCREEN RESULTS

Respond for ALL clients screened for cervical cancer

Has this client had a hysterectomy? ☐ Yes ☐ No

If "**Yes**" was the hysterectomy
Due to cervical neoplasia? ☐ Yes ☐ No
Or Is the cervix still present? ☐ Yes ☐ No

A client who has had a hysterectomy is eligible for an MBCHP Pap test if the hysterectomy was due to cervical neoplasia or the cervix is present

Respond for clients with a NORMAL Pap test result

Recommend the cervical cancer screening interval for this client.

- ☐ Short term follow-up, abnormal protocol
- ☐ Annual, conventional Pap test
- ☐ Every 2 years, liquid base cytology
- ☐ Every 3 years, 3 normal Pap tests within 60 months

Date of Pap test screening _____/_____/_____
Month Day Year

Pap specimen type ☐ Conventional ☐ Liquid

Adequacy of Pap specimen ☐ Satisfactory ☐ Unsatisfactory

Result of screening Pap test *(cervical results only)*

- ☐ Negative for intraepithelial lesion or malignancy
- ☐ ASC-US
- ☐ Low Grade SIL (including HPV changes)
- ☐ **ASC-H**
- ☐ **High Grade SIL**
- ☐ **Squamous Cell Carcinoma**
- ☐ **Abnormal Glandular Cells**

Date of HPV/DNA test _____/_____/_____
Month Day Year

High Risk HPV/DNA test results if done

☐ Positive ☐ Negative

Paid by MBCHP Pap test ☐ Yes ☐ No
HPV/DNA test ☐ Yes ☐ No

Reason for Pap test

- ☐ Routine screening
- ☐ Surveillance, follow-up of previous abnormal
- ☐ Done outside the MBCHP, diagnostics only
- ☐ Not done, diagnostics only
- ☐ Breast record only

Date referred to the MBCHP for diagnostic workup

Date referred _____/_____/_____
Month Day Year

Additional procedures

- ☐ Not planned, normal follow-up
- ☐ Planned, further diagnostic tests needed

Next Pap test or follow-up due _____/_____
Month Year

Recommendations/comments _____

_____

Print Provider's Name_____

Provider's signature_____